

HOUSE BILL No. 1258

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-131.8; IC 12-15-14.

Synopsis: Health facility reimbursement. Requires the office of Medicaid policy and planning to: (1) apply to the federal Centers for Medicare and Medicaid Services for an amendment to the state Medicaid plan to implement certain health facility reimbursement changes; and (2) authorize the collection of a licensing fee of \$6 from each health facility for each patient day; and provide for the deposit of the fee into the eldercare trust fund. Specifies how a health facility's annual licensing fee shall be calculated, depending upon whether the facility participates in the state Medicaid program. Requires the state's rate setting contractor to: (1) use the most recent completed year when calculating medians and provider rates; and (2) calculate the median for each rate component each quarter using all cost reports received by the state within a specified timeframe.

Effective: Upon passage; October 1, 2001 (retroactive).

Crawford

January 14, 2002, read first time and referred to Committee on Public Health.

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Introduced

Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

HOUSE BILL No. 1258

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-7-2-131.8 IS ADDED TO THE INDIANA
2 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
3 [EFFECTIVE UPON PASSAGE]: **Sec. 131.8. "Most recent year",**
4 **for purposes of IC 12-15-14-6(a), has the meaning set forth in**
5 **IC 12-15-14-6(a).**

6 SECTION 2. IC 12-15-14-1, AS AMENDED BY P.L.160-2001,
7 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
8 UPON PASSAGE]: Sec. 1. (a) Except as provided in subsection (b),
9 payment of services for nursing facilities shall be determined under the
10 same criteria and in a uniform manner for all facilities providing
11 services.

12 (b) In addition to reimbursement under the uniform rates of payment
13 developed for all nursing facilities under subsection (a):

- 14 (1) nursing facilities that are owned and operated by a
15 governmental entity may receive any additional payments that are
16 permitted under applicable federal statutes and regulations; and
17 (2) nursing facilities that are not owned and operated by a



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governmental entity may receive any additional payments that are permitted under applicable federal statutes and regulations.

(c) Each governmental transfer or other payment mechanism that the office implements under this chapter must maximize the amount of federal financial participation that the state can obtain through the intergovernmental transfer or other payment mechanism. **Any money used to generate additional federal financial participation under this chapter through an intergovernmental transfer or other payment mechanism and any additional federal financial participation or other additional payments that are received by the state through an intergovernmental transfer or other payment mechanism under this chapter shall be used to enhance reimbursement to nursing facilities.**

SECTION 3. IC 12-15-14-6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6. (a) As used in this section and for purposes of 405 IAC 1-14.6-7(a) and any successor rule, "most recent completed year" means the most recently completed fiscal year of the provider. The term does not mean the most recently completed cost reports on file.**

(b) Beginning April 1, 2002, the state's rate setting contractor shall use the most recent completed year when calculating medians and provider rates.

SECTION 4. IC 12-15-14-7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 7. (a) Beginning April 1, 2002, the state's rate setting contractor shall calculate the median for each rate component each quarter, using all cost reports received by the state or the state's rate setting contractor within one hundred fifty (150) days of each provider's fiscal year end.**

(b) The rate setting contractor shall request any additional information from a provider not later than twenty-one (21) days after the cost report is received by the rate setting contractor, and the rate setting contractor shall include in the medians and the provider's rate calculation all responses received within one hundred ninety (190) days after the provider's fiscal year end.

(c) If a draft audit report has been issued for a provider within one hundred fifty (150) days of the provider's fiscal year end, the rate setting contractor may request additional information relative to that draft audit report. If the draft audit report is issued later than one hundred fifty (150) days after the provider's fiscal year end, the rate setting contractor may not request additional

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information relative to that draft audit report for that rate review.

SECTION 5. [EFFECTIVE UPON PASSAGE] (a) The definitions in this SECTION apply throughout this SECTION and SECTIONS 6 through 13 of this act.

(b) "Bed" refers to a comprehensive care bed.

(c) "Fund" refers to the eldercare trust fund established by this act.

(d) "Health facility" means a health facility that is licensed under IC 16-28 as a comprehensive care facility.

(e) "Office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(f) "Patient day" means a patient day as reported on:

(1) a health facility's Medicaid cost report if the facility participates in the Medicaid program; or

(2) the form developed by the office under this act if the facility does not participate in the Medicaid program.

(g) This SECTION expires August 1, 2007.

SECTION 6. [EFFECTIVE UPON PASSAGE] (a) The eldercare trust fund is established. The fund consists of the money deposited in the fund from the licensing fee collected under this act.

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.

(d) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

(e) The money in the fund shall be used to pay the state's share of the costs to supplement and enhance reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(f) The money in the fund may not be used to reduce or replace the amount of state money that otherwise is being paid as nursing facility reimbursement as of January 1, 2002, or that otherwise would be paid after January 1, 2002, if this act had not been enacted to reimburse nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(g) All federal financial participation that is obtained due to the expenditure required by subsection (e) shall be expended to supplement and enhance reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social

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Security Act (42 U.S.C. 1396 et seq.).

(h) If federal financial participation becomes unavailable to match money from the fund for the purpose of supplementing and enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall cease collection of the licensing fee under this act and refund all the money remaining in the fund. The money shall be refunded to the providers that paid the money based on the amount of money paid by each provider.

(i) This SECTION expires August 1, 2007.

SECTION 7. [EFFECTIVE UPON PASSAGE] (a) Beginning August 1, 2002, the office shall collect a licensing fee from each health facility of six dollars (\$6) for each patient day in the health facility. The office shall deposit the money collected in the eldercare trust fund.

(b) This SECTION expires August 1, 2007.

SECTION 8. [EFFECTIVE UPON PASSAGE] (a) This SECTION applies only to a health facility that participates in the state Medicaid program.

(b) The office shall do the following:

(1) Determine the number of patient days for each health facility for the previous Medicaid cost reporting period.

(2) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days. The licensing fee shall be adjusted on an annual basis effective the first day of the second calendar quarter following the end of the facility's Medicaid cost reporting year.

(3) Notify each health facility each year not later than thirty (30) days after receipt of the facility's cost report of the amount of the annual licensing fee.

(4) Withhold one-twelfth (1/12) of each health facility's annual licensing fee each month through the Medicaid claims payment system. The annual licensing fee shall be collected against the claims for service dates that coincide with the time period that the licensing fee is in effect beginning in August 2002.

(c) The licensing fee collected under this act is considered an allowable cost for Medicaid reimbursement purposes in the administrative rate component (as defined in 405 IAC 1-14.6-2(a)).

(d) The office may not begin collection of the licensing fee under this act before the office calculates and begins paying new reimbursement rates under this act.

(e) This SECTION expires August 1, 2007.



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1 SECTION 9. [EFFECTIVE UPON PASSAGE] (a) This SECTION
2 applies to a health facility that does not participate in the state
3 Medicaid program.

4 (b) The office shall develop and distribute to each health facility
5 a form that will collect the following data:

6 (1) The total number of beds in the health facility.

7 (2) The number of patient days during the previous tax
8 reporting period.

9 (c) Each health facility shall complete and submit the form on
10 an annual basis not later than ninety (90) days after the end of the
11 facility's tax reporting period. The time period for this report is
12 equal to the health facility's tax reporting period.

13 (d) The office shall do the following:

14 (1) Determine the amount of the annual licensing fee for each
15 health facility based upon the number of patient days during the
16 previous tax reporting period. The licensing fee shall be
17 adjusted on an annual basis effective the first day of the
18 second calendar quarter following the end of the facility's tax
19 reporting year.

20 (2) Notify each health facility each year not later than thirty
21 (30) days after receipt of the health facility's form of the
22 amount of the annual licensing fee.

23 (e) Each health facility shall pay one-twelfth (1/12) of the
24 facility's annual licensing fee to the office not later than the tenth
25 day of each month beginning in August 2002 and ending in July
26 2007.

27 (f) If a health facility pays the health facility's annual licensing
28 fee after the tenth day of the month, the health facility shall pay
29 interest on the fee at the rate of fifteen percent (15%) annually. If
30 a health facility does not pay the health facility's licensing fee
31 within ninety (90) days after the date that a monthly payment is
32 due, the state department of health shall initiate a proceeding to
33 revoke the health facility's license under IC 16-28-3-1.

34 (g) This SECTION expires August 1, 2007.

35 SECTION 10. [EFFECTIVE UPON PASSAGE] (a) This
36 SECTION applies only to a health facility that participates in the
37 state Medicaid program.

38 (b) Before April 15, 2002, the office shall do the following:

39 (1) Determine the number of patient days for each health
40 facility for the previous Medicaid cost reporting period.

41 (2) Determine the amount of the annual licensing fee for each
42 health facility based upon the number of patient days.

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(3) Notify each health facility of the amount of the annual licensing fee.

(c) This SECTION expires July 1, 2002.

SECTION 11. [EFFECTIVE UPON PASSAGE] (a) This SECTION applies to a health facility that does not participate in the state Medicaid program.

(b) Before April 15, 2002, the office shall develop and distribute to a health facility a form that will collect the following data:

(1) Total number of beds in the health facility.

(2) Number of patient days during the previous tax reporting period.

(c) Before May 1, 2002, each health facility shall complete and submit the form. The time period for this report is equal to the facility's tax reporting period.

(d) Before June 1, 2002, the office shall do the following:

(1) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days during the previous tax reporting period.

(2) Notify each health facility of the amount of the annual licensing fee.

(e) This SECTION expires July 1, 2002.

SECTION 12. [EFFECTIVE UPON PASSAGE] (a) The state's rate setting contractor shall include in the calculation of:

(1) the administrative medians for rate effective dates of July 1, 2002, through September 30, 2003; and

(2) each provider's reimbursement rates with rate effective dates of July 1, 2002, through September 30, 2003;

the initial amount of the licensing fee that the provider will pay under this act.

(b) This SECTION expires January 1, 2004.

SECTION 13. [EFFECTIVE UPON PASSAGE] (a) Beginning April 1, 2002, the office shall recalculate, publish, and pay Medicaid reimbursement rates as modified by this act.

(b) The state's rate setting contractor shall calculate, using the most recently completed cost reports on file as of May 31, 2002, and notify providers of the providers' rates under this act not later than August 1, 2002.

(c) This SECTION expires July 1, 2007.

SECTION 14. [EFFECTIVE UPON PASSAGE] (a) The office shall not do any of the following:

(1) Repeal 405 IAC 1-14.6 without statutory authority.

(2) Amend 405 IAC 1-14.6 in any manner that reduces

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reimbursement for nursing facilities without statutory authority.

(3) Adopt or amend any other rule under IC 4-22-2 or any other statute that reduces reimbursement for nursing facilities without statutory authority.

(4) Repeal or amend a rule adopted under this act without statutory authority for the repeal or amendment.

(b) This SECTION expires July 1, 2007.

SECTION 15. [EFFECTIVE UPON PASSAGE] (a) Not later than July 1, 2002, the office of Medicaid policy and planning established by IC 12-8-6-1 shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to implement this act. However, approval of the state plan amendment by the federal Centers for Medicare and Medicaid Services is not required for the office to pay the modified reimbursement rates required by this act.

(b) This SECTION expires July 1, 2003.

SECTION 16. [EFFECTIVE OCTOBER 1, 2001 (RETROACTIVE)]

The following are void:

(1) LSA Document #01-351(E).

(2) LSA Document #01-352(E).

(3) LSA Document #01-353(E).

(4) LSA Document #01-354(E).

SECTION 17. An emergency is declared for this act.

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